

Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
15 MONTHS

TO BE FILLED IN BY OFFICE STAFF:

Last Name		First Name		AHCCCS ID		D.O.B.		Age (Months)	
Date of Examination	Ht. (in)	Percentile	Wt.(lbs)	Percentile	Head Circ. (cm)	Health Plan Name			

TO BE FILLED IN BY PROVIDER

HISTORY INITIAL/INTERVAL		T _____
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Comments	
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P _____

NUTRITIONAL ASSESSMENT [] Breast Feeding [] Whole Milk [] Cup [] Bottle [] Table Foods
Supplements: [] Fluoride [] Vitamins [] Iron

SENSORY ASSESSMENT Vision: Within normal limits? ☐ Yes ☐ No, Refer

Hearing/Speech: Within normal limits? ☐ Yes ☐ No, Refer

DEVELOPMENTAL ASSESSMENT Age appropriate? ☐ Yes ☐ No

Three to six words, points to one or more body parts, understands simple commands, walks well, climbs stairs, feeds self with fingers, listens to a story. (If suspicious, do specific objective testing) Assessment Tool (name) _____

PHYSICAL EXAM

Are the following normal?

	Yes	No
1. Do you have a current driver's license?		
2. Do you have a current vehicle registration?		
3. Do you have a current insurance policy?		
4. Do you have a current title?		
5. Do you have a current sales tax certificate?		
6. Do you have a current license plate?		
7. Do you have a current title transfer fee?		
8. Do you have a current title transfer tax?		
9. Do you have a current title transfer fee?		
10. Do you have a current title transfer tax?		

Skin		
HEENT		
Teeth		
Nodes		
Heart		
Lungs		
Abdomen		
Ext. Gen.		
Extremities		
Spine/Neuro		

LAB/SCREENING

Tuberculin Test		
	High	Low
Lead Screen: Verbal Risk		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed? ☐ Yes ☐ No

Follow-up needed? ☐ Yes ☐ No

IMMUNIZATION ASSESSMENT

Did this child receive all immunizations due today? ☐ Yes ☐ No

Did this child receive all immunizations due today? ☐ Yes ☐ No
Is there a current immunization record in the medical chart? ☐ Yes ☐ No

Is there a current immunization record in the medical chart? ☐ Yes ☐ No

Is there a current immunization record in the medical chart? ☐ Yes ☐ No

ANTICIPATORY GUIDANCE

-] Injury prevention
-] Good parenting practices
-] Tantrums
-] Eating

☐ Discipline/limits
☐ Sleep practices
☐ Nutrition
☐ Other

REFERRALS

☐ Dental (Baby bottle tooth decay)
☐ CRS
☐ WIC
☐ Specialty _____
☐ Other _____

ext scheduled visit

Clinician Name

Clinician Signature _____

Was this claim coded as an EPSDT Visit (HCFA-1500)? ☐ Yes ☐ No

[] No